vir 2 X 5 mg/kg body weight per day was re instituted. Within 2 weeks, pneumatos is and pneumoperitoneum had completely re solved. We suggest that a smouldering gastrointestinal CMV disease proven by biopsy 8 weeks before and incompletely suppressed by oral acyclovir was the cause of pneumatos is in our patient. Leukocyte CMV immediate early antigen remained negative, but this is known in an isolated gastrointestinal CMV disease, even if no specific suppressive therapy is used.5 Our ob servation is strikingly similar to the case reported by Mann es et al1 and emphasizes the fact mentioned by Rubin2 that gastrointes tinal CMV infection may present in this peculiar form and may respond to antiviral treatment. An additional symptomatic ther apeutic effect of metronidazole, however, cannot be excluded.

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REFERENCES

Describing a Pneumothorax

To the Editor:

The letter of Dr. Anthony Lopez et al1 commenting on the article by Engdahl et al2 illustrates a common clinical problem. As physicians and surgeons, we frequently receive reports from radiologists stating that there is a "mild," "tiny," "moderate," "large," or some other pneumothorax. The terms are all subjective and mean different things to different radiologists. Quantifying the pneumothorax by some of the esoteric, expensive, and possibly dangerous techniques described by the two authors does very little to help the clinician. The need for intervention will be based on the clinical condition of the patient as well as the absolute size of the pneumothorax.

I would suggest that, in clinical situations, less attention be paid to the numerical (percent) description of the pneumothorax. More attention should be given to description of the resultant air space within the hemithorax and whether that space is changing in size, eg, the left hemithorax contains a pneumothorax that separates the lung from the chest wall 4 cm at the apex, 2 cm in the upper lateral area, and 1 cm at the base of the lung. There is no separation at the base. Lateral view shows a pneumothorax separat ing the lung from the anterior chest wall by 3 cm. These findings demonstrate minimal change in the size of the pneumothorax seen on the x-ray film done 6 h earlier. Inspiratory effort is similar on both films.

Such descriptive reports would allow the clinician to visualize the problem and would obviate the need for an esoteric or inaccurate calculation of percent pneumothorax.

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REFERENCES

Should Supplemental Estrogen be Used as Steroid-Sparing Agents in Women With Asthma?

To the Editor:

I read with interest in the July 1994 issue of Chest the report by Myers and Sherman1 because their report adds support to the reports of others for the conclusion that levels of sex hormones affect bronchial inflammation. For example, Rubio et al2 concluded after measuring levels of steroid hormones in women with asthma that "bronchial asthma is associated in a high proportion with abnormalities in the production or metabolism of steroid hormones in women during their reproductive life." Therapeutically and similar to the report by Myers and Sherman,1 levels of sex hormones have been manipulated in women with asthma using danazol with beneficial results.3-5 Therefore, I agree with their conclusion that further studies concerning the role of sex hormones in women with asthma are needed.

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REFERENCES
1. Myers JR, Sherman CB. Should supplemental estrogens be used as steroid-sparing agents in asthmatic women? Chest 1994; 106:318-19

Management of Obstructive Sleep Apnea

To the Editor:

We read with interest the article in the July, 1993 issue of Chest by Coppola and Lawee1 concerning the use of portable sleep ap-